Appeals and Hearings

Chapter 6

DELETED

Chapter Reserved For Future Use

V. GRIEVANCES AND GRIEVANCE PROCESSING

A. Grievances and Grievance Processing

The Contractor shall develop and implement a *single automated* grievance system, separate and apart from the appeal process. The grievance system shall allow full opportunity for aggrieved parties to seek and obtain an explanation for and/or correction of any perceived failure of an in-system provider, the health care finder, or other Contractor or subcontractor personnel to furnish the level or quality of care and/or service to which the beneficiary may believe he/she is entitled. Any *TRICARE* beneficiary, sponsor, parent, guardian, or other representative who is aggrieved by any failure or perceived failure of the Contractor, subcontractor or contracted providers of service or care to meet the obligations for timely, quality care and service at appropriate levels may file a grievance. All grievances must be submitted in writing. The subjects of grievances may be, but are not limited to, such issues as *being denied a referral, the length of the* waiting period to obtain an appointment, undue delays at an office when an appointment has been made, improper level of care, poor quality of care, or other factors which reflect upon the quality of the care provided or the quality and/or timeliness of the service. If the written complaint reveals an appealable issue, the correspondence shall be forwarded to the Contractor's appeals unit for a reconsideration review.

1. Contractor Responsibilities

It is the Contractor's responsibility to conduct an investigation and, if possible, resolve the aggrieved party's problem or concern. In this responsibility the Contractor shall:

a. Ensure that information for filing of grievances is readily available to all beneficiaries within the service area.

b. Maintain a system of receipt, identification, and control which will enable accurate and timely handling. All grievances shall be stamped with the actual date of receipt within three (3) workdays of receipt in the Contractor's custody. The date of receipt shall be counted as the first day.

c. Investigate the grievance and document the results within sixty (60) days of receipt of the grievance. The Contractor shall notify the contracting officer of all grievances not reviewed within sixty (60) days of receipt.

d. Provide interim written response by the thirtieth (30) calendar day after receipt for all grievances not processed to completion by that date.

e. Take positive steps to resolve any problem identified within sixty days of the problem identification. If the problem cannot be resolved within that period of time, the contracting officer or contracting officer's representative shall be informed of the nature of the problem and the expected date of resolution. If there is no resolution to the problem, the Contractor should acknowledge receipt of the grievance and explain to the grievant why the problem cannot be resolved.

f. Written notification of the results of the review shall be submitted to the beneficiary within sixty (60) days of the original receipt of the grievance.

The letter will indicate who the grievant may contact to obtain more information and provide an opportunity to appeal a review decision of the grievance.

g. Ensure the involvement in the grievance review process of appropriate medical personnel, including personnel responsible for the Contractor's quality assurance program in any case where the grievance is related to the quality of medical care or impacts on utilization review activities.

h. Maintain records for all grievances, including copies of the correspondence, the results of the review/investigation and the action taken to resolve any problems which are identified through the grievance.

(b) Government Responsibilities

If the beneficiary or provider indicates dissatisfaction with the fact that a referral or subsequent care authorization was denied by the MTF, or that they believe a referral and subsequent care authorization would have been issued if the appropriate procedures had been followed, they shall be instructed to forward a written appeal to the TPO. The TPO will review care authorization appeals with an ad hoc committee, supplemented with the appropriate medical specialty. The beneficiary or provider may appeal the committee's decision to the TRICARE Commanders' Board for disposition. Each level of appeal will be complete within 30 days of receipt at the TPO.

(18) Patient Registration and Enrollment

Health Care Finders shall verify the CHCS registration status on every patient that calls the TSC. The HCF will perform enrollment activities as outlined in Section VII. of this document.

(19) Health Benefit Advisor (HBA) Functions

(a) "In Office" Functions

The Health Care Finders and/or Health Benefits Advisors at the TRICARE-Tidewater Service Center will assume the "in office" functions previously performed by the HBAs at the Naval Medical Center, Portsmouth. They will assist providers and beneficiaries seeking information on coverage questions, claims filing requirements, claims adjustments, status inquiries, etc. They will also distribute pamphlets, provider handbooks, and other marketing materials. They will serve as the focal point for information and assistance on CHAMPUS and TRICARE-Tidewater, including enrollment and information concerning educational opportunities.

(b) "Out of Office" Functions

Health Care Finders and/or Health Benefits Advisors at the TRICARE-Tidewater Service Center will not be required to participate in shipboard presentations, retiree days, wives' groups and other patient contact forums. Those functions will be performed by the appropriate MTF staff, augmented by TPO.

2. Appeals

The FI shall provide for an appeal system allowing full opportunity for proper appealing parties to appeal adverse factual determinations in accordance with the provisions of DoD Regulation 6010.8-R, Chapter 10, and the OPM Part Two, Chapter 6. The system shall include:

a. Adequate and timely notice of appeal rights. (OPM Part Two, Chapter 1, Section VI. and OPM Part Two, Chapter 6.)

b. A system of receipt, identification and control which will enable accurate and timely handling in accordance with the standards and requirements of the *OPM Part Three, Chapter 7.*

c. A process that ensures that 90% of FI reconsideration cases received at OCHAMPUS as a formal review case shall demonstrate accurate FI processing of the appeal, consistent with the COM-FI requirements and the documentation in the case file.

d. Establishment and maintenance of files relating to appeals which will enable the timely response to an OCHAMPUS requirement for a copy of the claim and appeal record and submission of the file copy in the form specified by OCHAMPUS. (See the *OPM Part Three, Chapter 7.*)

e. Timely reprocessing of adjustments resulting from appeals. (See the OPM Part Two, Chapter 6, Section I.A.)

f. Provision for effective review and control of the quality of appeal processing so that at least 90% of FI reconsideration cases demonstrate accurate FI processing of the appeal, consistent with the COM-FI requirements and the documentation in the case file.

3. Grievances

The TSC will use the FI developed grievance system, which is separate and apart from the appeal process. This grievance system shall pertain only to services received from network and non-network CHAMPUS providers, and shall not be applicable to services received from direct care providers. The TSC will refer complaints to the appropriate system, depending upon the nature of the complaint. The DoD Regional Review Centers (RRC) as described in Section VI. of this chapter, will handle all complaints related to quality and appropriateness of medical care for CHAMPUS inpatient medical and surgical services. Complaints or grievances regarding direct care providers will be forwarded to the appropriate MTF. The FI's grievance system shall allow full opportunity for the aggrieved parties to seek and obtain an explanation for and/or correction of any perceived failure of a network provider, the TRICARE-Tidewater Service Center or FI or subcontractor personnel to furnish the level or quality of services to which the party may feel he/she is entitled. Any patient, sponsor, parent, guardian or other representative may file a grievance or complaint. All grievances must be submitted in writing. The FI will process all grievances or complaints related to claims processing and the delivery of outpatient non-mental health care in Tidewater. The subjects of these grievances may include issues such as waiting period to obtain an appointment, undue delays at an office when an appointment has been made, lack of courtesy on the part of providers or their support staff or other factors which reflect upon the perceived quality of nonclinical services and/or the timeliness of all services. If the written complaint reveals an appealable issue, the correspondence shall be forwarded to the appropriate organization for the handling of the issue (the FI or the CRRC) for appropriate action within one workday of identification of the appealable issue. The responsible organization shall notify the grievant in writing that a review will be conducted.

a. FI Responsibilities

It is the FI's responsibility to conduct an investigation and, if possible, to resolve the aggrieved party's problem or concern. In their responsibility the FI shall:

(1) Ensure that information for filing of grievances is readily available to all beneficiaries receiving services from network and non-network providers.

(2) Maintain a system of receipt, identification and control which will enable accurate and timely handling. All grievances shall be stamped with the actual date of receipt within three (3) work days of receipt in the FI's custody. The date of receipt shall be counted as the first day.

V. APPEAL PROCESS & WAIVER OF LIABILITY

A. STSF NAS Denial Based on Availability of Care

When a beneficiary is denied an STSF NAS based on availability of care, the beneficiary may appeal the adverse STSF NAS decision following the same process as used for inpatient NAS. See OPM Part Three, Chapter 1, Section II.A.1.c. Lead Agents will ensure that NAS appeals for STS are decided within three (3) working days of receipt of each level of appeal.

B. STSF NAS Denial Based on Medical Necessity

Due process and consideration of appeals, as prescribed in *32 CFR 199.10 AND 199.15*, will be provided for any adverse decision regarding medical necessity, appropriateness, or reasonableness of care under TRICARE. The appeal process and the waiver of liability provisions that apply with regard to an inpatient NAS will also apply in connection with an STSF NAS. See OPM Part Three, Chapter 7, Section IV.

a For health care practitioners requiring MTF clinical privileges, the contractor shall furnish completed background check documentation to the MTF commander prior to the award of privileges.

b For individuals who require background checks but not clinical privileges, the contractor shall furnish the completed documentation to the MTF commander prior to employment at, or assignment to, the MTF.

c While waiting the thirty (30) day minimum period for a background check to be completed, the contractor shall follow the Criminal History Background Check Procedures outlined in Addendum C.

2 For certain physician (see subparagraph a below) and non-physician (see subparagraph b below) network providers, contractors may search federal, state, and county public records in performing criminal history checks. Contractors may subcontract for these services; for example, MEDI-NET, Inc., provides physician screening services, and ADREM Profiles, Inc., performs criminal history checks. The contractor shall document, in a form of the contractors' choosing, the AMA screen and the results of all criminal history checks.

a The contractor shall screen all network physicians' licensure and discipline histories using the American Medical Association's (AMA's) master file and shall perform criminal history checks on physicians with licensure anomalies [i.e., who have four (4) or more active and/or expired licenses] or who have been disciplined; and

b The contractor shall perform criminal history checks on all non-physician providers who practice independently and who are not supervised by a physician (refer to DoD 6010.8-R Chapter 6, Section C.3., for types of providers).

3 The contractor shall maintain a copy of all background check documentation with the provider certification files as required by Addendum B.

4 The contractor is financially responsible for all credentialing requirements, including background checks.

(5) All acute care hospitals in the network shall be members of the National Disaster Medical System (NDMS) network unless it can be shown that they do not qualify for membership.

NOTE:

The Contracting Officer may approve waivers of this requirement on a case-by-case basis. All waiver requests shall be submitted through the Lead Agents to the Contracting Officer.

b. Participation on Claims

All network provider contracts shall require the provider to participate on all claims and submit claims on behalf of all TRICARE and Medicare beneficiaries.

(1) Balance Billing

Providers in the contractor's network may only bill TRICARE beneficiaries for applicable deductibles, co-payments, and/or cost-sharing amounts; they may not bill for charges which exceed contractually allowed payment rates. Network providers may only bill MTFs for services provided active duty service members at the contractually agreed amount, or less, and may not bill for charges which exceed the contractually agreed allowed payment amount. The contractor shall include this provision in provider contracts and shall provide the Lead Agents and each MTF Commander with a list of all network providers, their addresses and phone numbers, their specialties or types of service (DME, supplies, etc.), and their contractually agreed allowable amount (discounts or price list) by the tenth (10th) calendar day prior to the start of health care delivery and by the tenth (10th) calendar day prior to the start of each calendar quarter thereafter. (Such lists shall be provided in an electronic or paper format acceptable to the Lead Agent.)

(2) Billing for Non-Covered Services *(Hold Harmless)*

No payments may be required for any noncovered service which a beneficiary receives from a network provider *(i.e., the beneficiary will be held harmless)* unless the beneficiary has agreed in advance *in writing* to pay for such a service. (See OPM Part Three, Chapter 7, Section II.D. for additional details.)

c. Access Standards

The network shall include a complement of civilian providers to ensure access to care for the TRICARE Prime and Extra programs' beneficiaries. Access shall comply with the following guidelines:

(1) Number and Mix of Providers

The network shall include the number and mix of providers, both primary care and specialists, necessary to satisfy demand and to ensure access to all necessary types and levels of primary care. Overall provider availability should be in a ratio of one provider (all physician categories) to every 1,200 TRICARE Prime enrollees. The Primary Care Manager (PCM) requirement is a ratio of one PCM to every 2,000 enrollees. Provider requirements are expressed as full-time equivalents.

(2) Delivery Sites

Except for any special services not sufficiently available in the area to make inclusion in the network practical, the network shall include sufficient delivery sites to ensure access to care. The contractor may request exceptions for a special services not sufficiently available in the area to make inclusion in the network practical. Such requests shall be submitted through the Lead Agent to the Contracting Officer for approval.

(3) Primary Care Availability

The network shall include primary care delivery sites to ensure that beneficiary travel time does not exceed 30 minutes from home to delivery site. An exception may be granted only when longer travel time is justified by the absence of providers in the area. The contractor shall submit requests for exceptions through the Lead Agents to the Contracting Officer.

provided by their PCM, must be referred from the PCM and authorized by the Health Care Finder or other contractor designee. This requirement is applicable for services referred to the MTF when the enrollee has been assigned a PCM in the network or for services referred to a provider outside the MTF when the enrollee has been assigned an MTF PCM.

NOTE:

Nonenrolled beneficiaries are not required to obtain authorization for care from the Health Care Finder except when an NAS is required. Providers serving nonenrollees shall comply with the prior authorization requirements established under OPM Part Three, Chapter 3, Section I.B.3.b.

(2) The Health Care Finder authorization functions shall include first level review of all referrals for medical necessity, for those admissions and procedures that require preauthorization, as outlined in OPM Part Three, Chapter 3 and Chapter 5. Also, the review will include the determination that care was referred from the PCM. In addition, MTF commanders may give Health Care Finders written authorization to perform the authorization functions for referrals from MTF PCMs to other MTF providers. MTFs that desire contractor support for this provision are identified in OPM Part Three, Chapter 5.

c. Nonavailability Statements (NASs)

MTF Commanders may give Health Care Finders written authorization to issue Nonavailability Statements (NASs) on their behalf, and the contractor shall perform these functions in accordance with DoD NAS requirements (See DoD Instruction 6015.19, as implemented by TRICARE/CHAMPUS Policy Manual, Chapter 11, Section 2.1. and OPM Part Two, Chapter 1, Section IV.E.). Such authorizations shall be by mutual consent of the contractor and the MTF commander. Specific policies and procedures shall be addressed in the MOU between the contractor and the MTF Commander. Health Care Finders shall coordinate all NAS requirements with MTF Health Benefits Advisors. (If the NAS issuance function is retained by MTF personnel, they shall coordinate the NAS issuance closely with the Health Care Finder in order to ensure that the appropriate clinical review is accomplished before issuing an NAS.)

(1) For nonenrollees, after a determination is made that care cannot be provided in an MTF and prior to issuing an NAS, the contractor shall review the request to determine the medical necessity of the requested medical service. Requirements for determining clinical necessity are established in OPM Part Three, Chapter 1, Section II.A.1.c.

(2) When authorized by the MTF Commanders, Health Care Finders shall consider the availability of services from MTF providers, in *deciding* whether to issue an NAS. If the care that is determined medically necessary is not available in the MTF, then a NAS will be issued. (See TRICARE/CHAMPUS Policy Manual, Chapter 11, Section 2.1. which contains DoD Instruction 6015.19, "Issuance of Nonavailability Statements"; and OPM Part Two, Chapter 1, Section IV.E.)

(3) *When the care is found to be medically necessary, but the beneficiary is denied an NAS because the care is available at an MTF, and the beneficiary is not satisfied with the decision, the beneficiary's only remedy is to seek* an administrative review from the MTF commander in accordance with DODI 6015.19.

d. Other Functions

The Health Care Finders shall inform beneficiaries of access mechanisms, referral procedures, and rules regarding use of providers. They shall also improve patient continuity of care by establishing mechanisms to facilitate necessary consultations, follow-up appointments, and the sharing of medical records (see OPM Part Three, Chapter 5).

2. Qualification of the Health Care Finders

Health Care Finders who perform the first level review functions as part of the authorization process for medical and surgical referrals shall be qualified physicians, registered nurses or physician assistants. In cases of mental health services, the contractor shall use licensed psychiatric nurses or other mental health professionals. Qualification requirements are further stated in OPM Part Three, Chapter 3, Section I.A.4. Health Care Finders who perform duties such as appointing and scheduling, that do not require clinical judgment, may have administrative or clerical qualifications.

B. Specialty and Tertiary Care

In each catchment area, the MTF is the first choice provider for all nonemergency specialty and inpatient care for the TRICARE program unless otherwise indicated by the MTF Commander. The contractor is responsible for coordinating the referral function for both beneficiaries and network providers through administration of a Health Care Finder program (Section II.A. of this section). If services are not available at the MTF, the beneficiary shall be referred to the contractor's network through Health Care Finders. If the required care is not available in the network, the health care finder shall arrange for care through a nonnetwork provider. The contractor shall ensure that all specialty and tertiary care for enrollees, whether provided in the MTF or in the civilian network, has been authorized.

C. Specialized Treatment Services (STSs)

DoD is in the process of developing Specialized Treatment Services such as the Wilford Hall Bone Marrow Program. (See OPM Part Two, Chapter 20.) These facilities shall be considered the preferred facilities for all MHS beneficiaries for the particular speciality services offered. These facilities take precedence for specialty care referrals for all TRICARE patients to the extent that they are available.

Health-Care Services - Utilization and Quality Management

Table of Contents

Table of Contents